LOS ANGELES COUNTY
HIV PREVENTION PLANNING COMMITTEE (PPC)
A Select Committee of the Commission on HIV Health Services
600 South Commonwealth Avenue, 6th Floor•Los Angeles CA 90005-4001

MEETING SUMMARY
Thursday, April 7, 2005
12:00 PM - 4:00 PM
St. Anne's Maternity Home - Foundation Conference Room
155 N. Occidental Blvd.-Los Angeles, CA 90026

MEMBERS PRESENT		ABSENT
Jeff Bailey	Mario Pérez*	Diane Brown
Vanessa Talamantes*	Chi-Wai Au*	Manuel Cortez
Jose Roberto Barahona*	Richard Browne*	
Gordon Bunch	David Giugni	
Jeffrey King*	Elizabeth Mendia*	
Veronica Morales	Ricki Rosales	
Kathy Watt	Freddie Williams*	
Richard Zaldivar		

* Denotes present at one (1) of the roll calls

OAPP STAFF PRESENT

Erica Angert	Arthur Durazo	Elizabeth Escobedo	Jay Gabor	Michael Green
Mike Janson	John Mesta	Saloniki Osorio	David Pieribone	Jane Rohde
Cheryl Williams				

I. ROLL CALL

Roll call was taken at 12:10 PM.

II. COLLOQUIA PRESENTATION

Dr. Deborah Cohen, RAND Corporation, described a study that indicates that the closure of alcohol outlets caused by the 1992 Civil Unrest resulted in declines in gonorrhea titled The 1992 Los Angeles Civil Unrest and the Impact on Gonorrhea. As a result of the decision to acquit three Los Angeles Police Officers on April 29, 1992 in the Rodney King case, there were three days of violence and mayhem; people began rioting, businesses and schools were closed and the National Guard was deployed to Los Angeles. Two hundred and seventy alcohol outlets were required to surrender their liquor license because of damage (predominately in South Los Angeles). Studies of alcohol outlets and risk behavior indicate that there is an association. In 1995, there was a study that showed a 10% increase in alcohol outlets and its association with an almost 6% increase in gonorrhea. The 1992 civil unrest provided an opportunity to study how alcohol outlets and neighborhood damage might influence gonorrhea rates over time. Gonorrhea was mostly concentrated in the area that was affected by the civil unrest. The gonorrhea rate was very high. In the late 1980's, there were over 100,000 cases annually. Baseline data indicate, on average, there were 309 cases of gonorrhea per 100,000 people. The findings of the study support a direct link between alcohol availability and sexually transmitted diseases. Community efforts to limit alcohol outlets in local neighborhoods could be considered for STD and/or HIV prevention interventions.

QUESTION: Is there any way to take into account some of the social reactions to the riot?
ANSWER: Absolutely, there was a lot more community intervention and that could have made the difference or contributed to it.

The second presentation by Dr. Cohen reviewed the findings of a study that uses cost effectiveness to determine which combination of HIV prevention interventions should be selected to cut HIV transmission by 50% titled How to Cut HIV Transmission in Half: A National Cost-Effective HIV Prevention Portfolio. The HIV epidemic has not declined in the past 5 years, it has been stable. Approximately 40,000 new HIV infections occur annually and the Centers for Disease Control and Prevention (CDC) goal has been to reduce this number in half. We should apply principles of cost effectiveness to the allocation to prevention resources. Cost effectiveness is measured by the money needed to prevent one case of HIV transmission. Cost effectiveness is estimated as

- What an intervention costs?
- How many people do they reach?
- What were the risk behaviors before and after?

Less than 10% of all dollars for HIV is spent on prevention and 90% or more is spent on treatment. A tool was developed to assess the cost effectiveness of HIV prevention intervention, called Maximizing the Benefit. There is a link to this tool on the CHIPTS website. 26 different interventions were reviewed.

The CDC is spending almost 400 million dollars a year on HIV prevention. The model was based on spending 400 million dollars to prevent at least 20,000 cases annually. The study estimated that the number of Injection Drug Users (IDU) was 1.75 million in the United States and their rate of HIV varied. In Los Angeles, the rate of HIV among IDU is 2%. The study estimated there are 1.75 million Men who have Sex with Men (MSM) and their rate of HIV infection is 20%. There are less than ½ million HIV + people estimated to be in medical care. It is estimated that 1/3 of HIV infected people do not know they are infected.

QUESTION: Are you saying less than 20% of MSM in urban areas are positive?
ANSWER: That is an estimate based on the CDC's surveillance data. It varies across cities.

Including, the following assumptions into our model, we came up with a ranking of interventions that are cost effective and could be paid for by this $400 million that the CDC allocates for HIV prevention. The cheapest and most cost effective intervention was to show videos in STD clinics. There are studies that have shown that they change risk behavior after receiving some education.
Some of the other cost effective interventions are:

- Partner notification (about $250 per person)
- Community mobilization (using Mpowerment model)
- Screening HIV + people for STDs
- Needle Exchange
- Mass Media Programs
- Opinion Leader Programs
- Condom Availability Programs
- HIV Counseling and Testing

The CDC's new prevention strategy is to:

- Make HIV testing a routine part of medical care
- Use new models to diagnosis HIV outside of traditional settings
- Prevent new infections by working with HIV+ individuals and their partners
- Decrease mother to child transmission

QUESTION: (Kathy Watt) Where did you get the figures for the interventions? In this country, who is getting $5,000.00 per person in drug and alcohol treatment?
ANSWER: If someone is in a program, what do you think it costs them for treatment? That is what the costs are for outpatient treatment.
COMMENT: (Kathy Watt) I am an executive director of a Drug and Alcohol Program and it does not cost…

QUESTION: What are you spending for treatment for somebody? Say the individual is in a Methadone clinic, what is the cost?

QUESTION: (Richard Browne) Is that $5,000 per episode or a slot cost for one year?
ANSWER: Yes, I think this figure came from a Methadone clinic.
COMMENT: (Richard Browne) O.K., there are a variety of modalities. Methadone is somewhere between $5,000 to $6,000 per year in terms of what Medi-Cal reimburses for. An outpatient slot at some places is between $4,000 to $5,000 per year. In Los Angeles County, a residential slot is between $18,000 to $30,000 per year.

COMMENT: (Dr. Cohen) I'm not saying we shouldn't be doing drug treatment, I am saying when you talk about cost effectiveness for HIV prevention …

COMMENT: (Kathy Watt) MSM's addicted to Crystal Meth, drug treatment is very cost effective.

QUESTION: (Dr. Cohen) How much would 30-day residential treatment for Crystal Meth cost?
ANSWER: about $422.50.

QUESTION: (Kathy Watt) How many episodes of transmission risk are you preventing by someone who has been using Crystal Meth and been having 5 to 10 sex partners per day? If that individual is in treatment for 30 days, many potential/possible infections have been averted.

COMMENT: (Dr. Cohen) When we looked at MSM in general, we said the average number of sex partners was 3.

QUESTION: (Kathy Watt) For what period of time?
ANSWER: About every 3 months.

QUESTION: Can you explain how reliable the study is since you are relying on the literature? It appears some of the methodology in the literature is flawed.
ANSWER: Nothing is perfect.

QUESTION: What do you think of the CDC's new prevention strategies of making HIV testing a routine part of accessing medical care?
ANSWER: They (CDC) would rather people do HIV Counseling and Testing rather than any of the other interventions.

QUESTION: Isn't that under the assumption that most of our at-risk populations have access to medical care?
ANSWER: You're right. I think that is the wrong approach because we are not going to be able to reach all of the people who are positive. They want people to do mobile teams out in the community and a lot of people do want to be tested. If they got a message that their peer group thinks it is "cool" to use condoms or if they could get free condoms somewhere that might make more of a difference.

COMMENT: The Los Angeles Unified School District receives about $353,000 per year directly from the CDC to address the needs of a couple of hundred thousand junior and high school teenagers and our condom use is slightly above the national average and our pregnancy rate is down in the district. There have been a number of NIH studies that indicate school health education can be very cost effective for alcohol control, tobacco control and some other health issues.

QUESTION: If ¼ of all the new infections occur among people under age 25, don't you think it would be appropriate to address prevention before unhealthy behaviors take effect?
ANSWER: Yes, but how do it? Condom availability programs should be cost effective. If you have free condoms in local neighborhoods, kids will see that message. If you have billboards like the STOPS AIDS campaign in Switzerland, those are the types of things we should be doing. So that low risk groups, young people see these messages. We are not giving those messages in this country.

COMMENT: There really isn't that much funding for school education. The State of California has refused to accept some federal money because the State of California recognizes that it is not effective in changing youth behavior.

QUESTION: You have no information on the transgender community so are you not counting the transgender community? Or are you counting transgender as MSM? If you are counting transgender as MSM, how are you getting your numbers for transgender community around HIV and AIDS being developed if you are trying to attack the intervention/prevention around high-risk youth?
ANSWER: We included transgender with the MSM. There aren't a whole lot of studies on enough people that we were able to include something separately on transgender in this study. It would be more cost effective for the transgender community than for other groups because the rates of HIV infection tend to be higher.

QUESTION: How would you go about doing that in the sense that transgender's have specific needs (transgender men and women) as well as specific needs that are not going to be targeted?
ANSWER: The things that we talk about regarding changing risk behaviors are condom use, number of sex partners, and frequency of sex. I don't think there is anything different in transmission dynamics for the transgender population than the MSM.

COMMENT: If you are working on the street and you are trying to make some money, there is a difference between a transgender being at high-risk.
COMMENT: I think we are talking about two separate things. When we calculated transmission (based on the route of exposure), the transmission is either from vaginal intercourse, anal intercourse, oral intercourse, frequency of sex partners, the number of people you have sex with and injection drugs.

COMMENT: (Richard Zaldivar) I don't think anyone knows what the cost effectiveness of any prevention effort really is. Also, it is perplexing and frustrating to me (being in this field for 10 years) that we keep throwing out the number 40,000 cases on a national level. I think the prevention efforts that have been funded have been very effective in keeping that number where it is. I don't hear the reality or truth about HIV because I think it is too complex. I think we had a poor opportunity to be cost effective in the 1980's and we did not participate or do that then. I think this is out of control and the reality is it is going to take a lot of more money and a lot more integrated effort to lower and to put the epidemic in it's tracks.

COMMENT: (Dr. Cohen) The CDC estimates that the epidemic is stable. It could be we are having an impact but I would like for us to have more of an impact and reduce the rate.

COMMENT: One of the things you discussed was showing videos at STD clinics, there is no literature out there for transgender persons that make them feel comfortable.

COMMENT: (Mario Pérez) I think that there were a couple of assumptions not mentioned at the beginning. For several years we have become accustomed to hearing the 40,000 mark but in the United States we reached a peak in the early 1990's of about 120,000 new HIV infections each year and we have managed through our prevention efforts (largely in urban America) to reduce that number to 40,000 and we still expect largely that those infections are happening in urban America but that reduction maintenance of infections has happened despite two things: 1) the essential freezing of HIV prevention increases across the country and Dr. Holgrave has clearly articulated that an increase in the investment would translate into a reduction of new infections. The other thing you failed to mention is there has been since the early 1990's an increase in the people living with HIV or AIDS in this country. I think those two factors are important when we begin to look at why that 40,000 number can't be broken.

COMMENT: (Mario Pérez) I wanted to say a couple of things about AHP. The CDC assumes that 2/3 of the new HIV infections or about 27,000 to 41,000 infections occur or involve folks that are undiagnosed. We estimate in the United States, there are 230,000 people who are undiagnosed and we think there are about 13,000 people in Los Angeles County that are undiagnosed. I think that one of the issues that make your presentation so provocative is that it is assuming infections averted and for many of us that is not a concrete measure. None of us can go home, can go back to our office, can go back to our clinics and measure infections averted without longitudal studies so we have to rely on more concrete measurements like the number of people newly diagnosed and for counseling and testing in Los Angeles County we can quantify pretty effectively how much it costs us to diagnosis someone with HIV in a medical clinic, in a storefront setting, in a commercial sex venue, through PCRS. We have some

pretty good ideas of where it is more cost effective. One challenge would be to have RAND help us with the cost effectiveness study to look at how much it would cost to diagnosis someone in the five, six or seven venues where we have testing available that might help the Prevention Planning Committee earmark some of its testing resources a little bit more effectively. I think we can't ignore the fact that many of the infections in this country happen because we are not diagnosing enough folks and if we really want to have an impact on the 40,000 we need to diagnosis individuals and I don't want people leaving thinking that we should decrease our investment in counseling and testing, let's increase in proportion investment.

COMMENT: (Mario Pérez) In Los Angeles County, it is a disservice to talk about drug treatment without distinguishing between Crystal Meth use and Heroin use. We have long understood that Heroin users in our county, there are some protective affects in place (needle exchange, black tar Heroin, things that have been demonstrated to decrease the number of new infections) and if we talk about drug treatment I maintain that investment in the drug treatment of Meth users would have a profound effect on adverting new HIV infections in our county. I think your example assumes partner notification should be offered once and only once and we have tried to implement a new approach that involves offering PCRS throughout the course of a person's infection with HIV because we can't rely on that partner notification episode ten years ago having impact on the 28 other partners that has been since then. I think that is an important clarification for future presentations. Although your 1.2 billion dollars seems high for screening Americans who have not been screened, it is still only 40% of the daily cost of the war in Iraq.

COMMENT: (Dr. Cohen) You mentioned some good points, if we put more money in HIV prevention, we would prevent more cases. I would love to see the data on your continued counseling of partner notifications because I think that is a fabulous approach because they are a high-risk group and I have not seen anything published on whether contacting people after initial partner notification makes a difference. If you can somehow gather that data and put it together and see if it makes a difference. I would like to get some data on the Crystal Meth and drug treatment because maybe that is an exception that that would be cost effective if risk behaviors are some much higher that it puts lots of people at risk.

III. REVIEW/APPROVAL OF MEETING AGENDA

The draft meeting agenda for April 7, 2005 was reviewed and approved by consensus.

IV. REVIEW/APPROVAL OF MARCH 3, 2005 MEETING SUMMARY

The draft meeting summary for March 3, 2005 PPC meeting was reviewed and approved by consensus.

V. PUBLIC COMMENT

- Dani Mejia, APAIT, announced The Banyan Tree Project (BTP) a groundbreaking, year-round national campaign to fight HIV related discrimination and stigma in Asian and Pacific Islander communities. The Banyan Tree launches Thursday, May 19, 2005 with the first annual National Asian and Pacific Islander HIV Awareness Day in the United States.
- Shirley Bushnell, APAIT, announced a new program for the Transgender Population titled: "STAR" (Serving Transgenders At Risk).
- Kafi Battersby, Reach Los Angeles, announced the 2005 Youth HIV Prevention Conference titled: "Building bridges between service providers and their allies to stop HIV/AIDS among youth in Los Angeles County". The conference will be held on Wednesday, April 27, 2005 at Almansor Court. Flyers are available on the back table.
- Kafi Battersby, Reach Los Angeles, announced Reach LA will be posting available positions next week for two Peer Educator positions and one Coordinator position.
- Ruth Slaughter, PROTOTYPES, announced and extended an invitation to the 15th Annual Skills Building Conference titled: Healing Our Village 2005 on May 12, 2005 at the Four Points Sheraton Hotel at LAX.
- Craig Vincent-Jones, Commission on HIV Health Services, introduced some of CHHS management staff: Doris Reed, Operations Manager; Glenda Pinney, Planning Manager and Assistant Director; and Gary Garcia, Evaluation Manager.
- **ASK THE PPC QUESTION** –from the audience. An individual is looking for information about the National HIV Prevention Conference. *RESPONSE*: There are two conferences this

summer. The National HIV Prevention Conference is sponsored by the CDC in Atlanta. The second conference is HIV Prevention Leadership Summit (HPLS) in San Francisco. Check websites to register for these conferences.

VI. PPC SUBCOMMITTEE OPEN HOUSE

1. This open house is being hosted to introduce or remind providers of the PPC subcommittees
2. Discuss the goals and objectives of each subcommittees
3. Discuss the mission of each subcommittee
4. Describe the purpose of each subcommittee and explain how that impacts the delivery of services in Los Angeles County
5. With the commencement of new prevention contracts effective January 1, 2005, the PPC wanted to ensure that all (new and veteran) providers feel welcome and understand the process of the PPC and encourage all to participate in the HIV Prevention Planning Committee.

The audience broke out in three small groups, formed semi-circles, and the PPC subcommittee members moved around to each group. Time allocated was 15 minutes per group.

VII. BREAK

VIII. OVERVIEW OF THE COUNTY OF LOS ANGELES HIV PREVENTION PLAN 2004-2008 PRESENTATION

Mario Pérez presented a power point presentation overview of the newly released County of Los Angeles HIV Prevention Plan 2004-2008. The presentation overview consisted of: review HIV Prevention Plan timeline, review HIV Prevention Plan development efforts, review HIV Prevention Plan sections, review HIV Prevention Plan utility and review opportunities and plans for updates.

Timeline

2003

- PPC launches planning process
- Process coincides with the release of CDC Community Planning Guidance
- Planning process influenced by Advancing HIV Prevention Initiative: New Strategies for a Changing Epidemic
- PPC adopts Addendum to 2000-2003 Plan
- Community Needs Assessment process planned

2004

- Needs Assessment process implemented
- Updated Epidemiologic Profile incorporated
- First draft Prevention Plan available for review

2005

- HIV Prevention Plan released
- Addendum incorporating Community Needs Assessment anticipated

2005-2008

- Updates to various sections will be incorporated

Prevention Plan Development Efforts

- Facilitated Behavioral Risk Group and Priority Population focused Meetings
    - Young Women at Sexual Risk (YWSR)
    - Men who have Sex with Men (MSM)
    - Young Men who have Sex with Men (YMSM)
    - Men who have Sex with Men and Women (MSM/W)
    - Injection Drug User (IDU)
    - Men who have Sex with Men who are Injection Drug User (MSM/IDU)
    - Persons Living with HIV
- The PPC created the HIV Prevention Plan Ad-Hoc Subcommittee
    - Comprised of the PPC and Community Members
- Continued PPC Colloquia presentations and prioritized most relevant presentations

- Conducted inventory of Countywide HIV prevention resources
- Updated Resource Allocation Recommendations
- Updated Intervention recommendations

Prevention Plan Sections

- Overview of HIV Community Planning
- HIV Epidemiologic Profile
- Community Assessment
- Priority Populations
- Interventions
- Evaluation
- Geographic Snapshots
- Appendices

HIV Community Planning (pages 5-14)

- History of Community Planning in Los Angeles County
- CDC's Community Planning Guidance
    - Performance Indicators
- CDC's Advancing HIV Prevention Initiative
- Mission
- Vision
- Core Objectives
- Membership (Table 2)
- Subcommittees
- Planning Process

HIV Epidemiologic Profile (pages 15-57)

- Developed by the Los Angeles County HIV Epidemiology Program
- Consistent with CDC and HRSA Guidance
- Focuses on BRG's and Priority Populations
- Emphasizes presentation of information by Service Planning Area (SPA)
- Does not include Non-AIDS HIV-Infection data
- Relies on Surveillance Data, Estimate of HIV Prevalence, Data from HIV Seroprevalence Studies and other data sources
- Four Major Sections
- General Description of Los Angeles County
- Trends in the HIV/AIDS Epidemic
    - Los Angeles County – United States Comparisons
    - Trends by Mode of Exposure, Race, Age Groups
    - HIV/AIDS Burden Estimates (Table 3)
- Geographic Distribution of HIV/AIDS across the County
    - Data by Service Planning Area (SPA)
- Distribution of HIV/AIDS among Priority Populations
    - Data by BRG (Table 8)
    - Data on American Indians
    - Data on Co-Morbidities

Community Assessment (pages 58-89)

- Description of Four Step Approach
    - Analysis of current HIV Epidemiologic and related data
    - Analysis of HIV Risk Behavior Information
    - Gathering of qualitative data through focus groups (Appendix)
    - Gathering of qualitative information from individuals at risk for HIV not receiving services (forthcoming)
- Analysis of HIV Risk Behavior Information
    - Countywide Risk Assessment Survey

- Supplement to HIV/AIDS Surveillance Project (Table 13-16)
- Comparison of First HIV Diagnosis and AIDS Diagnosis (Table 17)
- Assessing Prevention Needs by Priority Group
- Analysis of HIV Risk Behavior Information
    - Available Resources to Address Need
        - Training
        - Capacity Building
        - Early Intervention Programs
        - HIV Epidemiology Program Studies
        - CDC AHP and 04064
        - California Office of AIDS
        - Office of Minority Health
        - Special Projects of National Significance
        - Local City Efforts
        - Research and Academic Partners

Priority Populations (pages 90-95)

- Description of Prioritization Process
- 2004-2008 Priority Populations (7+2)
    - Recommended Resource Allocations
- Geographic Estimate of Need (GEN)
    - GEN by SPA (Table 22)
    - Recent AIDS cases by SPA and Race/Ethnicity (Table 23)

Interventions (pages 96-112)

- Emphasis on Evidence of Effectiveness and Behavior Change Theory
    - Summary of Behavioral Theories (9)
    - Summary of Evidence of Effectiveness
- Intervention Types and Performance Indicators
- Recommended Allocation by Prevention Service Type (Table 24)

Evaluation (pages 113-118)

- Guided by 2001 CDC Evaluation Guidance
- Three Essential Evaluation Components
    - Evaluating the Community Planning Process
    - Evaluating HIV Prevention Interventions and Related Programs
    - Tracking the CDC required Program Performance Indicators
- Nine Program Performance Indicator Tables (Page 116)
    - HIV Community Planning
    - Newly diagnosed HIV infections
    - HIV Testing
    - Partner Counseling and Referral Services (PCRS)
    - Prevention Case Management
    - HIV Prevention Interventions & Outreach
    - Perinatal Transmission
    - Evaluation
    - Capacity Building

Geographic Snapshots (pages 119-128)

- Service Planning Areas (SPA)
    - Population
    - Size
    - District and County Board of Supervisor
    - Socio-Demographic Profile
    - People Living with AIDS (PLWA)
    - Other Health Indicators

Appendices (A1-A73)

- References
- Technical Notes
- Population Ranking
- Acronyms and Common Terms
- Description of Selected Studies
- Description of Selected Interventions
- Focus Group Raw Data for BRG's

Uses of the Prevention Plan

- Tool to develop, target and refine HIV Prevention Programs
- Reference document for the writing of grants
- Tool to improve understanding of HIV trends
- Tool to improve the understanding of Behavioral Theory
- Summary of HIV Prevention Research and Science

Opportunities and Plans for Updates

- Annual updates expected
- Significant changes made through addenda
- Open and participatory feedback process
- Evaluation of the Prevention Plan encouraged

QUESTION: (Shirley Bushnell) If we were not here when the Prevention Plan CD-Rom was distributed, how can we get a copy?
ANSWER: There are copies of the Prevention Plan on CD-Rom in the back for people to take.

QUESTION: Did you mention when the hard copies will be available?
ANSWER: (John Mesta) We received revised bids on the printing of the Prevention Plan last month, so we hope to have a turn-around within the next month or so. We have copies of the CD in the back and the plan is also available on the website.

IX. STATE OFFICE OF AIDS UPDATE

Mario Pérez introduced Kevin Farrell of the State of California Office of AIDS. Mr. Farrell provided some information on activities occurring at the State Office of AIDS. The California HIV Planning Group is meeting in West Hollywood on May 4th and May 5th. The State Office of AIDS in conjunction with Los Angeles County Office of AIDS Programs and Policy, the San Francisco Department of Public Health and a couple of other partners will sponsor a Transgendered Conference in San Francisco from May 17th through May 19th.

The Prevention Planning funding formula is about to be implemented with the new State fiscal year (July, 2005). Eleven (11) local health jurisdictions were able to get significant increases in their education and prevention funding as a result of the reconfiguration of the formula. Los Angeles was one of the health jurisdictions and approximately $1.6 million new dollars will be coming to Los Angeles effective July 1, 2005.

The State Office is working on a number of specific high-risk initiatives. One of the initiatives is around Crystal Meth and another is around Syringe Exchange. Last year, the Governor signed AB 1159, which allows people to obtain up to ten syringes from a pharmacy. The State Office is working to create a demonstration project to work with the pharmacy companies in California to help them understand the law and be willing to distribute needles/syringes to people who come in and request to get the syringes.

The State Office is stepping up its efforts in the area of Hepatitis. It is hoped that a Hepatitis Specialist will be hired by the State sometime this summer.

In January, 2005 the Oral Rapid Test was approved. Throughout the State, in general, there may be barriers to implementing Rapid Testing. In the first quarter of 2005, only about 4,000 Oral Rapid Test have been requested from the Clearinghouse. About 50% of the health jurisdictions in California have a

Rapid Test Program of some kind. The ultimate goal is to have almost 100% of the tests in California (about 200,000 per year) conducted using the new Rapid Test technology. The State Office is encouraging all of the testing to be high-risk testing. Currently, 25% of all prevention dollars go to working with HIV positives.

QUESTION: Are you still taking applications for the CHGP?
ANSWER: No, the membership for the CHGP has been selected and it is closed for 2005 but it opens up again November 15, 2005 for 2006 membership.

The State Office hired MacArthur Fleunoy, an African American HIV Specialist and the State Office intends to hire a Latino HIV Specialist.

X. ELECTION OF COMMUNITY CO-CHAIR

John Mesta announced there will be a special recognition for Jeff Bailey at the next PPC meeting.

Vanessa Talamantes expressed appreciation and "Thank You" to Jeff Bailey for being a colleague and mentor.

Mario Pérez commented on Jeff Bailey as being responsive, dedicated, and most committed to the HIV prevention program in Los Angeles County. Additionally, Mr. Pérez commented that Jeff Bailey is a true leader, a visionary and embraced the concepts of community planning by reaching out to our community partners and other community members. Thank You for all of your hard work and Thank You to the Los Angeles Gay and Lesbian Center for their willingness to allow Jeff to comprehensively serve his county.

Kathy Watt thanked and commended Jeff Bailey for extending his term as Community Co-Chair for an additional year so that we could see the Prevention Plan through.

Vanessa Talamantes reported nominations for community co-chair opened at the last (March 3, 2005) PPC Meeting. Kathy Watt was nominated and accepted. Prior to closing the nomination for Community-Co Chair, Vanessa Talamantes asked if anyone would like to nominate someone. Richard Zaldivar made a motion to nominate Ricki Rosales as Community Co-Chair and the motion was seconded. Ricki Rosales accepted the nomination.

Both candidates made a position statement.

Vanessa Talamantes made a motion to close the nominations and Jeff Bailey seconded the motion.
A Hand Vote was conducted:
Kathy Watt 6
Ricki Rosales 7
Abstention 1

Ricki Rosales was elected as Community Co-Chair. Vanessa Talamantes announced Ricki Rosales as Community Co-Chair.

XI. COMMUNITY CO-CHAIRS REPORT

No report.

XII. GOVERNMENTAL CO-CHAIR REPORT

Mario Pérez reported the HIV Prevention Programs that were recently funded appear to be on track with all program requirements, evaluation plans, quality assurance plans, etc. Those services should be in full force if not now certainly within the new few weeks. If there was a hiccup or interruption in prevention activity, we suspect that is not going to happen for long.

Mario Pérez reported information on Diffusion of Effective Behavioral Interventions (DEBI) trainings. The Office of AIDS Programs and Policy (OAPP) funded a broad set of interventions from the CDC's DEBI document. OAPP is actively facilitating trainings for those interventions. OAPP is trying to locally host as many trainings as it can although, it does appear that there may be a need to send people

outside of the jurisdiction to get those training needs met. For the next 30 or 40 days, there will be a lot of correspondence regarding the availability of those trainings (i.e. how to get people signed up very quickly, how to get to the trainings in some instances for multiple days, and how to finance the cost of those trainings).

XIII. SUB-COMMITTEE REPORTS

- **Operations** – Veronica Morales reported Save the Dates of December 5th and December 6th for the next PPC Annual Planning Meeting. The Operations subcommittee will brainstorm on the Youth Leadership Institute for the next few months. A PPC recruitment email has been sent to the extended contact list with the new PPC application. The next meeting is scheduled for April 12th. Veronica Morales placed a motion on the floor to approve Tim Young and Dani Mejia for PPC membership. The motion was seconded. The motion was approved by consensus.

- **Evaluation –** Gordon Bunch reported the Evaluation Subcommittee did not meet last month and will meet this month on April 19th from 3:00 PM - 5:00PM in Conference Room C at OAPP.

- **Standards & Best Practices –** Jeff Bailey reported the Standards and Best Practices subcommittee met last month and discussed recommendations for the Venue-Based Task Force Meeting, which included developing a list of events that take place throughout the year that trigger HIV risk behaviors. A calendar will be developed so that people can be responsive to those types of days. In June, 2005, West Hollywood will be sponsoring HIV Prevention Month. The Standards and Best Practices subcommittee had a discussion regarding the minimum and preferred competencies of HIV Prevention staff and the recommendations that the Standards & Best Practices subcommittee would like to forward to the PPC.

  In reference to the Venue-Based Task Force, Mario Pérez encouraged the Venue Based Task Force to consider having someone from the Service Provider Networks provide an overview of the progress with the coordinated service plan. David Pieribone, OAPP, reported that recently the Service Provider Networks produced three maps (medical services, prevention services and social and client services) and they (the Service Provider Networks) are willing to present the maps to the Venue-Based Task Force.

- **Commission on HIV Health Services (CHHS) Report –** Elizabeth Mendia reported the CHHS met on March 10th. The CHHS Public Policy Committee forwarded two motions: Oppose SB 235 the with "specific intent" language and endorse implementation of SB1159 which would authorize licensed pharmacists to sell or furnish 10 or less hypodermic needles or syringes without a prescription. Kathy Watt reported the CHHS has requested to present on "Names Based reporting" to the PPC.

XIV. ANNOUNCEMENTS

- Jeff Bailey announced that the PPC meetings start at 12:00 noon.
- Elizabeth Mendia announced LACADA is hosting a community forum on May 16th at 6:00 PM at the Whittier Senior Center.
- Richard Zaldivar requested a moment of silence for Pope John Paul II.

XV. CLOSING ROLL CALL

XVI. ADJOURNMENT – Meeting adjourned at 4:25PM.
Note: All agenda items are subject to action.

MOTION AND VOTING SUMMARY		
MOTION: #1: Approve the Agenda order.	Passed by Consensus	**Motion Passed**
MOTION # 2: Approve the Meeting Summary from the March 3, 2005 Meeting.	Passed by Consensus	**Motion Passed**
MOTION #3: Close PPC Community Co-Chair nominations	Passed by Consensus	**Motion Passed**
MOTION #4: Elect PPC Community Co-Chair	Voting Summary Kathy Watt 6 Ricki Rosales 7 Abstention 1	**Ricki Rosales elected as Community Co-Chair**
MOTION #5: Approve Tim Young and Dani Mejia for PPC membership	Passed by Consensus	**Motion Passed**

NOTE: All HIV Prevention Planning Committee (PPC) meeting summaries, tapes and documents are available for review and inspection at the Office of AIDS Programs and Policy (OAPP) located at 600 South Commonwealth Avenue, 2nd Floor, Los Angeles, CA 90005. To make an appointment to review these documents, please call Cheryl Williams at (213) 351-8126.

cw(PPC04-07-05min) Revd05-04-05